TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AT&T, INC. EMPLOYEE BENEFIT PLAN

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-14-2885-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
May 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I represent Optum o/b/o AT&T, Inc. Employee Benefit Plan (a subclaimant), pertaining to their reimbursement claim against Travelers Indemnity Company of Connecticut (the worker's compensation carrier). Enclosed please find a supplemental form DWC060 Medical Fee Dispute resolution Request, along with the medical payment Summary for each bill (EOB) and copies of the supporting bills, in duplicate."

Amount in Dispute: $756,833.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With the reimbursement being issued, the Carrier contends the Group Health Carrier is not entitled to additional reimbursement. The Carrier, therefore, respectfully requests the Group Health Carrier withdraw this Request for Medical Fee Dispute Resolution upon receipt of the supplemental reimbursement, or in the alternative, that the Division determine no additional reimbursement is due for this service."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
September 2, 2011 through October 17, 2013	Facility and Professional Services	$756,833.54	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §409.0091 sets out the reimbursement procedures for health care insurers.
2. Texas Labor Code §402.084 sets out the procedures for Record Check; Release of Information.

Issues

1. Does Texas Labor Code §409.0091 apply to this request for dispute resolution?
2. Did the workers compensation insurance carrier issue a payment after the filing of the Medical Fee Dispute?
3. Did the health care insurer meet the applicable requirements of Texas Labor Code §409.0091?

Findings

1. Texas Labor Code §409.0091 was added by Acts 2007, 80th Leg., R.S., Ch. 1007 (H.B. 724), Sec. 8, and is effective for dates of injury on or after September 1, 2007, with few exceptions. The requestor of this medical fee dispute is Optum c/o AT & T, Inc. Employee Benefit Plan, an authorized representative of AT & T, Inc. Employee Benefit Plan – a health care insurer as defined by Texas Labor Code §409.0091(a).

   Optum and AT & T, Inc. Employee Benefit Plan are collectively referred to as the subclaimant for the purposes of this medical fee dispute. Texas Labor Code §409.0091(c) states that health care paid by a health care insurer may be reimbursable as a medical benefit.

   The subclaimant alleges it paid for services provided to an injured employee with a compensable Texas workers' compensation claim and is seeking to recover $756,833.54 from Travelers Insurance - a Texas workers' compensation insurance carrier – hereto referred to as the carrier. The provisions of Texas Labor Code §409.0091 apply to this request for reimbursement and are hereby considered.

2. The division reviewed the workers' compensation insurance carrier's response, which contained copies of EOBs to support that a payment was issued to the subclaimant in the amount of $216,702.70 after the filing of the MDR. The subclaimant submitted a supplemental response indicating that Optum continues to pursue dispute resolution for the balance of $540,130.84 on behalf of AT & T, Inc. Employee Benefit Plan. The Division will therefore review the disputed services and consider whether the requestor is entitled to additional reimbursement for the remaining disputed services.

3. Texas Labor Code §409.0091 outlines the process by which a health care insurer as defined by Texas Labor Code §402.084(c-1) may be reimbursed by a workers' compensation insurance carrier. A data match pursuant to Texas Labor Code §402.084(c-3) is therefore required by Texas Labor Code §409.0091.

   The requestor did not submit documentation to support that it received a data match pursuant to Texas Labor Code §402.084(c-3) from the Division. Review of the documentation provided by the requestor finds the following.

   - The requestor provided a position summary, with no indication as to when the data match was obtained from the Division.
   - Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that a data match occurred prior to the filing of the medical fee dispute. Due to the insufficient documentation, the Division is unable to verify that the data match occurred prior to the filing of the MDR. The Division finds that the requestor is therefore not eligible to file for reimbursement from the workers' compensation insurance carrier under Texas Labor Code §409.0091.

   Texas Labor Code §409.0091(n) states, "Except as provided by Subsection (s), a health care insurer must file a request for reimbursement with the workers' compensation insurance carrier not later than six months after the date on which the health care insurer received information under Section 402.084(c-3) and not later than 18 months after the health care insurer paid for the health care service."

   - Review of the submitted documentation finds that the requestor submitted insufficient documentation to support that a data match occurred. The Division is therefore unable to establish that the timeframes outlined above were met by the requestor.

   The Division concludes that the requestor submitted insufficient documentation to reasonable support that it met the conditions of §409.0091.

Conclusion

The outcome of this medical fee dispute relied upon the available evidence presented by the requestor and the respondent. Even though all the evidence was not discussed, it was considered. For the reasons stated above, the Division finds that the requestor failed to establish that additional reimbursement is due. As a result, the amount ordered is zero.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 12, 2017
Signature	Medical Fee Dispute Resolution Officer	Date
		April 12, 2017
Signature	Medical Fee Dispute Resolution Director	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.